

Imposed Death

Euthanasia and Assisted Suicide

Advertising Supplement



Imposed Death

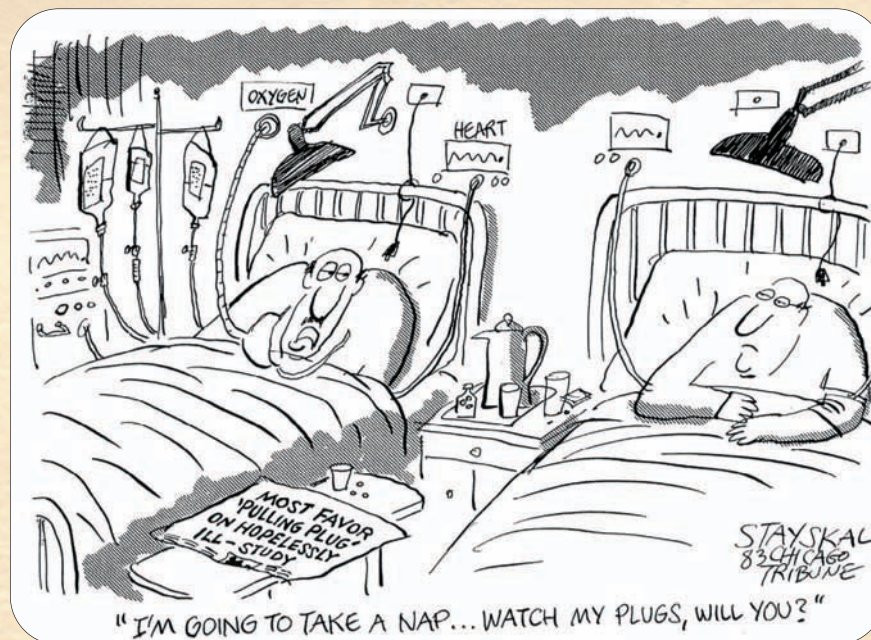
Features

- 4 **Living Wills: Vital... or Deadly?**
A Living Will may be a license to kill.
- 5 **"Persistent Vegetative State"**
How reliable is a PVS diagnosis?
- 8 **Thirsty? Too Bad.**
Withholding food and water is the new "mercy killing."
- 11 **Hospice Care: The Good, the Bad and the Ugly**
by **Tracy Berntsen** ♦ Tread carefully when you select a hospice.
- 12 **Terri Schiavo: A Senseless Death**
The story of one disabled woman's fight for life.
- 3 **Euthanasia and Assisted Suicide: What in the World is Going On?**
The imposed death agenda creeps across the globe.
- 6 **The History of Imposed Death in America**
How the right-to-die agenda has infiltrated America.
- 9 **Would you never want to be hooked up to a machine?**
by **Marlene Reid** ♦ It might just save your life.
- 10 **Organ Donors Wanted: Dead or Alive!**
by **Dr. Paul A. Byrne** ♦ Dead by whose definition?

Additional Features

A Time to Let Go
Not Dead Yet
Save a Life
Thanks for all the fish!
Follow the Money
Organ Donors, NOT "Brain Dead"
A Brother's Grief

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Human Life Alliance is a non-profit, pro-life, educational organization dedicated to protecting human life from fertilization until natural death.

HLA creates educational publications on abortion, abstinence and euthanasia.

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Euthanasia literally translated from the Greek means "good death." Some who promote euthanasia call it "mercy killing." Death by euthanasia is neither good nor merciful. Therefore, in this publication, the more accurate term "imposed death" is frequently substituted for "euthanasia" and also for "assisted suicide." (See Definitions, p.3)

You may ask, "Why should I be concerned? Why do I need to read this publication?"

Because the entire human race has a stake in the answer to the question, "Should imposed death be permitted and regulated by law?" History teaches us that a society which does not respect and protect all human life will ultimately bring about its own destruction.

Allowing the lives of certain people to be terminated because they are viewed as "not worth living" or "burdensome" has profound repercussions for all of us. Devaluing one human life devalues all human life. (See the true stories highlighted in our Case in Point Features.)

What's the Big Deal?

This supplement examines the history of imposed death, the facts about it and the experiences and opinions of those most intimately affected by it. You need the unvarnished truth in order to make informed decisions about such vital matters.

Advocates of euthanasia and assisted suicide use terms like "choice in dying" and "self-determination." They promote the social and legal acceptance of the "right to die"—that is, the "right" for individuals to choose how, when, where and why to die, and to receive assistance in dying from others. Although the expression "right to die" is seductive, it is fundamentally anti-libertarian. Giving the State the right to authorize our "right to die" begins the progression from voluntary imposed death to involuntary imposed death. Who will decide for those who cannot make their own choices? At what point does a "right" become an expectation, even a duty?

Instead of pursuing a "right to die," let us strive to create an environment—a culture of life—in which no person feels compelled to seek the "quick

fix" of death and every person's life is respected by society and protected by law.

ACKNOWLEDGMENTS

Human Life Alliance assembled a talented team of writers, researchers and experts who contributed to developing this supplement. We are grateful to these men and women for their dedication to this project, as well as for their perseverance in defending the unalienable right to life of all human beings, especially those who are most vulnerable, the voiceless. Foremost, we want to thank our multitude of friends whose faithful support enables Human Life Alliance to continue its life-saving educational projects.

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Euthanasia and Assisted Suicide: What in the World is Going On?

The Netherlands and Belgium are the only nations in the world so far that have legalized active euthanasia and physician-assisted suicide (PAS). Switzerland has not legalized PAS, but liberally allows it. In the United States, although euthanasia by action is not legal, "living will" laws and court decisions have ushered in euthanasia by omission. "Right to die" activists in the U.S. have waged battles to legalize PAS in many states, but have managed to win in only one—Oregon. In 1994, Oregon voters narrowly (51%) approved the "Death With Dignity Act." They had been led to believe that the Act would restrict PAS to cases of unbearable, uncontrollable pain. That's what they approved, but what did they actually get?

Oregon - We'll Help You Die!

Delayed by legal challenges, Oregon's "Death With Dignity Act" did not become operative until 1997. By the end of 2005, physicians had reported 246 suicides using physician-prescribed drugs. These patients' principal concerns were "decreasing ability to participate in activities that made life enjoyable" and "loss of autonomy"—not pain.¹ The Act, in fact, does not mention pain as a justification for PAS. It merely requires the diagnosis of a terminal illness that will lead to death within six months.²

Predictions of life expectancy are unreliable. Two patients who received prescriptions in 2001 were still alive more than a year later—one died in 2003, the other was still alive at the end of 2003.³ Isn't it probable that some patients who killed themselves would have lived longer than six months? Might some physicians "help" non-terminally ill patients commit suicide?

The law requires doctors to report all prescriptions for PAS, but Oregon conducts no independent reviews to verify that doctors are complying, so there really is no way of knowing the actual number of PAS deaths or the reasons for them.

The Hippocratic Oath states, "I will give no deadly medicine to anyone even if asked," but today very few

physicians make that promise. This anti-Hippocratic climate disposes physicians to do whatever the patient, physician or even the state wants.

Oregon rations health care. Its "Prioritized List of Health Services for Medicaid Patients" will not allow payment for treatment of many types of cancer unless the patient has at least a five percent chance of living another five years. So, a patient with cancer of the bowel, for example, who might live a few more years with treatment to slow the cancer's progress, will not be treated. Yet Oregon will pay for PAS as "comfort care" for Medicaid patients.

PAS creates less concern for providing the best medical treatment and more concern for cost-containment. PAS discriminates against low-income patients who are old, sick, or disabled by offering them drugs to die rather than reasons to live. Oregon's taxpayers did not vote to pay for killing the poor.

Understanding Gonzales v. Oregon

In 2001, Attorney General John Ashcroft issued a directive that physicians could lose their federal registration to prescribe controlled substances if they prescribe them for assisted suicide because it is not a "legitimate medical purpose." His successor, Alberto Gonzales, agreed. In 2004, the Ninth Circuit Court declared that Ashcroft had overstepped his authority and the U.S. Supreme Court agreed to hear the case of *Gonzales v. Oregon*.

On January 17, 2006, the Supreme Court ruled 6-3 that the Controlled Substances Act (CSA) does not address assisted suicide and therefore Ashcroft did not have the authority to prohibit doctors from prescribing federally controlled drugs for PAS. Contrary to the spin PAS supporters put on this decision, the Court did not uphold Oregon's law nor did it endorse assisted suicide. In fact, the justices in the majority agreed that the federal government possesses the power to prevent narcotics from being prescribed for PAS, for example, by amending the CSA.

The Netherlands - We Euthanize Children!

In 2001, as a mere formality, the Netherlands legalized assisted suicide and euthanasia. Wesley Smith, an attorney and author of numerous books on bioethical issues, neatly summarizes the progression of medical killing in the Netherlands:

First, Dutch euthanasia advocates said that patient killing will be limited to the competent, terminally ill who ask for it. Then, when doctors began euthanizing patients who clearly were not terminally ill, sweat not, they soothed: medicalized killing will be limited to competent people with incurable illnesses or disabilities. Then, when doctors began killing patients who were depressed but not physically ill, not to worry, they told us: only competent depressed people whose desire to commit suicide is "rational" will have their deaths facilitated. Then, when doctors began killing incompetent people, such as those with Alzheimer's, it's all under control, they crooned: non-voluntary killing will be limited to patients who would have asked for it if they were competent. And now they want to euthanize children.⁴

In 2004, Groningen University Hospital decided to permit its doctors to euthanize children under the age of 12 with or without the parents consent.⁵ By the end of 2005, the Netherlands was setting up a commission to regulate the practice of ending the lives of "seriously suffering" newborn babies.

Belgium - Get a Euthanasia Kit!

In 2002, a new Belgian law went into effect that allows a physician to euthanize an adult patient who requests it because of a "hopeless" medical condition and unbearable physical or mental pain that cannot be controlled. With modern palliative care, very few people should fit that description. Nevertheless, the government reported that in the first year after the law took effect over 250 Belgians were legally killed!

In 2005, pharmacies in Belgium began selling "euthanasia kits" containing all

the necessary materials to efficiently kill a patient. A kit costs about 60 euros (\$77).

Switzerland - You'll Never Take Another Vacation!

Switzerland is becoming known for its "suicide tourism." The non-profit organization Dignitas, headquartered in Zurich, assists foreigners who want to die. They fly to Zurich where Dignitas takes care of everything from supplying the drugs to disposing of the body. Dignitas has recently expanded its operations by opening a branch office in Hanover, Germany.⁶

Unlike other countries, Switzerland has not considered assisted suicide a "medical treatment." However, that is changing. Lausanne University Hospital decided to permit assisted suicides starting January 1, 2006. Other hospitals are debating whether to follow suit.

Does Legal Equal Ethical?

Legalizing medical murder does not change a crime into a medical treatment; rather, it turns the law itself into an accessory to murder.

- 1 Eighth Annual Report on Oregon's Death With Dignity Act. Oregon Department of Human Services. 3/9/06
- 2 Ibid.
- 3 Stevens, Kenneth MD. "Latest assisted suicide report should be cause for alarm," *The Oregonian*. 3/12/04.
- 4 Smith, Wesley J. "Now They Want to Euthanize Children." www.weeklystandard.com, 9/13/04
- 5 Hewitt, Hugh. "Death by Committee." *The Weekly Standard*. 12/2/04. www.weeklystandard.com.
- 6 Whitlock, Craig. "Branching Out to Serve a Growing but Dying Market." 11/1/05 www.washingtonpost.com.

Information

International Task Force on Euthanasia and Assisted Suicide
www.internationaltaskforce.org

Physicians for Compassionate Care Educational Foundation
www.PCCEP.org

Euthanasia: Euthanasia means an act or omission intended to cause death in order to eliminate suffering. The act or omission is committed by someone other than the person being euthanized, allegedly for his/her benefit.

- ♦ Euthanasia can be an action, such as a lethal injection, smothering or shooting.
- ♦ Euthanasia can be an omission, such as withholding or withdrawing necessary and ordinary (beneficial, usual, and not excessively burdensome) medical care and treatment, or food and fluids.

There is no moral distinction between an act that is intended to cause death and an omission that causes death. The victim is equally as dead.

Definitions

- ♦ Euthanasia can be voluntary—the person requests or gives consent to be killed.
- ♦ Euthanasia can be involuntary—the person does not give consent or is incapable of giving consent to be killed.

Mercy Killing: Euthanasia is sometimes called mercy killing. "Mercy" describes the (assumed) motive. "Killing" describes the act.

Assisted Suicide: Suicide is self-murder. In assisted suicide, the means—drugs, gun, plastic bag,

instructions for their use, counseling, etc.—are provided by someone else, but the last act is done by the person being killed.

Physician-Assisted Suicide: Physician-Assisted Suicide means that a physician provides the means for a person to commit suicide.

Aid in Dying: Aid in Dying is a euphemism for assisted suicide and euthanasia.

Imposed Death: Imposed Death is an umbrella term which covers all acts of killing human beings either in order to end their suffering or to relieve others of the duty to care for them.

Living Wills: Vital... or Deadly?

Advance directives for health care are legal documents by which individuals express their wishes in case they are ever unable to make health care decisions for themselves. There are two types: the Living Will and the Durable Power of Attorney for Health Care (DPAHC). Some advance directives are a combination of the two.

The laws governing Living Will and DPAHC documents permit the withholding or withdrawal of ordinary treatment and care, including food and fluids, even when the omission will be the direct cause of death. Thus, these documents can be used to license euthanasia. The wrong kind of advance directive in the wrong hands can be a deadly combination.

Federal regulations require every health facility and program that receives Medicare and Medicaid funds to inform patients about advance directives. Many hospitals and nursing homes give patients a Living Will or DPAHC to sign at the time of admission, a time when most people are under stress and distracted by other paperwork and questions. This is not an ideal circumstance for considering a legal document with life and death consequences. It is wise to arrive with your own carefully prepared directive in hand.

When considering an advance directive, you will need to understand the significant differences between the two types.

A Living Will is downright dangerous. It gives an attending physician

—very likely a stranger—the power to make life and death decisions for you. A doctor may do a poor job of deciphering your wishes, particularly if he/she does not share your moral values. Furthermore, real end-of-life decisions often involve complicated medical and ethical questions that can't be answered in a Living Will.

Keeping an open mind to the future is essential. It is impossible to give or withhold consent to treatment based on guesswork about a future illness or injury, and without knowledge of potential future treatment options. Nevertheless, the directions you give in a Living Will, by law, must be followed. Therefore, you may tie the hands of a physician whose skills could restore you to health or save your life. The directions in a Living Will are either so vague as to be useless or so specific as to be hazardous.

A Durable Power of Attorney for Health Care document is a better option. In a DPAHC you specifically name a trusted family member or friend ("agent") to make decisions for you if you are unable—either temporarily or permanently—to do so for yourself. Your "agent" will endeavor to make decisions in accord with your personal values and wishes. Your "agent" will base medical decisions on knowledge of your actual condition and treatment options, not guesswork.

It is important to discuss your wishes with your "agent" on a continuing basis. Preferences tend to change over time. Particularly as health declines, patients often accept

medical interventions they previously thought they would never want. Many people are not comfortable talking about aging, illness, injury and death. However, as difficult as it may be to discuss these issues ahead of time, during a medical crisis it may be even more difficult or even impossible.

As with any legal document, the wording of a DPAHC is critically important. Also, it must comply with the laws in your state. That is why Human Life Alliance recommends the Protective Medical Decisions Document (PMDD)* formulated by the International Task Force on Euthanasia and Assisted Suicide. The PMDD gives your "agent" the authority to act on your behalf and take legal action, if necessary, to insure that your rights are protected. The PMDD clearly states that your "agent" does not have the authority to approve the direct and intentional ending of your life. This limitation not only protects you, but it also protects your "agent" from being subjected to pressure to authorize such actions.

A Durable Power of Attorney for Health Care is absolutely essential for anyone who is 18 years or older. To be certain that a person you trust will be making medical decisions for you if you become incapacitated by an injury or illness, you must have specifically named that person in a legal document.

Filling out a PMDD takes only a few minutes - a few minutes that may mean the difference between life and death.

Information

*To obtain a PMDD packet specific to your state, contact: International Task Force on Euthanasia and Assisted Suicide, P.O. Box 760, Steubenville, OH 43952; 800-958-5678.

Advance Directives: Who Needs Them? (6 pages), 2004, International Task Force on Euthanasia and Assisted Suicide, 800-958-9678.

Life, Life Support and Death: Principles, Guidelines, Policies and Procedures for Making Decisions to Protect and Preserve Life. 2nd Ed. 2005, American Life League, 540-659-4171.

A Time to Let Go

There may come a time when it is medically indicated and morally permissible to forgo a specific treatment or other medical intervention.

Insistence against the patient's wishes that every means available be used to postpone death is contrary to law, and would be senseless and inhumane. There is no moral or ethical requirement to provide or obtain treatment that is ineffective. Those treatments that are extremely burdensome, overly zealous, or otherwise extraordinary are optional. However, people who want treatment should not be denied it.

We must be careful that what we judge to be a "burden" is NOT the

patient's life, and that the particular

treatment is truly a burden to the patient - not to the family, insurance company, hospital or state.

If a time comes when it is impossible to heal or cure, we do not deliberately hasten the death of a person. We change our roles. We become CARE givers, doing what we can to meet the physical, emotional, social and spiritual needs of the person who is sick or dying.

A balanced view accepts the morality of refusing unduly burdensome or ineffective treatment while rejecting imposed death. There is a world of difference between "allow her to die" and "kill her off."

"Persistent Vegetative State"

The dehumanizing label "persistent vegetative state" (PVS) was crafted in 1972 just as the euthanasia movement began to build up steam. It became more familiar in the 1980s as neurologists began to use it to justify withdrawing food and water from otherwise non-dying brain-injured patients.

Many people have blind faith in medical labeling. Most probably think that PVS is a simple diagnosis. However, experts disagree about what it is and

methods for diagnostic testing are disputed. In the International Classification of Diseases, PVS is grouped with "Symptoms, Signs and Ill-Defined Conditions."

A "vegetative state" is not a coma. According to the 1994 Multi-Society Task Force (MSTF) on the medical aspects of PVS, a person in a coma is neither awake nor aware; a person in a vegetative state is awake but not aware. The MSTF defined "persistent vegetative state" as a vegetative state that lasts more than one month.¹ PVS can last for many years; however, the longer a person is in PVS the less likely it is that they will have a significant recovery.

The person in PVS has sleep-wake cycles, eye movement, and normal respiratory, circulatory and digestive functions. Some have random movement, some do not; some can swallow, others cannot. Some have been physically injured; others suffer from stroke or dementia. In some cases the brain itself appears to change, in others it appears unchanged.

In simple terms, the diagnosis of PVS is based on a lack of evidence of awareness of self or environment. However, it is not that simple.

Some patients who are diagnosed in PVS do exhibit evidence of awareness, but the diagnostician misses (or dismisses) the evidence. They may be mute and immobile ("locked-in"), but mentally alert and able to communicate by blinking or through aids such as computers—if someone gives them the opportunity. Others retain some measure of awareness even though they do not exhibit any evidence of it. Patients who have recovered from such a state can recall things that were said or done to them while no one knew they were aware.



How reliable, then, is the diagnosis of PVS?

- ◆ In 2002, a study of mistaken diagnosis of PVS revealed a 15% error rate.²
- ◆ Data gathered by the MSTF on a group of 434 adult patients who

were in PVS as a result of traumatic injury showed that three months after injury, 33% of the patients had regained consciousness; by six months, 46% had; and at 12 months, 52% had.³

- ◆ Out of 40 patients diagnosed as being

in PVS, 17 (43%) were later found to be alert, aware, and often able to express a simple wish. The author, London neurologist Dr. Keith Andrews, said, "It is disturbing to think that some patients who were aware had for several years been

treated as being vegetative."⁴

Studies show that PVS patients feel pain. A University of Michigan neurologist, in one of the most complete studies, concluded that, when food and fluids are withdrawn (to impose death), the patient should be sedated.⁵

Some objections to imposed death for patients in PVS have rested on the hope that they might recover. Let's face it: many people with disabilities will not recover—but killing them is not a cure!

It is now common for persistently unresponsive or minimally responsive patients—who are not dispatched by dehydration in a hospital or hospice—to end up warehoused in nursing homes, deprived of rehabilitation and other beneficial medical treatment. The unconscious world is far more complex than most of us can imagine. Patients with severe brain damage may still enjoy touch, taste, smell and sound; they may also feel loneliness, fear, despair and pain.

A patient's inability to satisfy our

longing for response does not justify abandonment or imposed death.

1 Mappes, Thomas A. "Persistent Vegetative State, Prospective Thinking and Advance Directives," *Kennedy Institute of Ethics Journal*. 2003: Vol. 13. No. 2: 119-139.

2 Ibid.

3 Ibid.

4 *British Medical Journal*. 7/6/96

5 *Detroit Free Press*. 6/26/90

Case in Point

Arthur Wold, 30, had been labeled "severely mentally retarded" from age four. Unable to control his body, he could make only random gestures and say isolated words. But, in 1991, at a sheltered workshop, a counselor offered him a computer keyboard. He typed, "My name is Art." No one ever suspected he could read. When asked if he preferred to be called Arthur or Art, he spelled, "I don't care, just don't call me stupid." (*Parade Magazine*, 9/20/92)

Not Dead Yet

circumstances in the past?

- ◆ How the medical tests run after Poutre's biological mother saw signs of responsiveness could be so wrong. Accepting the test results as incontestable, doctors again told the Department of Social Services that there was "not a chance" of recovery. A few days later, Poutre became responsive. These tests are obviously fatally flawed.

- ◆ How Baystate Medical could support the incorrect diagnosis just eight days after Poutre's admission. In January, Dr. Douglas Katz, medical director of the traumatic brain injury program at Braintree Rehabilitation Hospital, stated, "I wouldn't give up before a year." (*The Boston Globe*, 1/27/06) Is giving up after eight days standard operating procedure at Baystate? Have this hospital and others allowed children with brain injuries to die under such rushed circumstances?

- ◆ Whether this rush to withdraw life support from brain injured patients is accepted medical practice in Massachusetts. Baystate doctors claimed their recommendations were in line with established medical ethics. Perhaps we need some new ethics.
- ◆ How the Juvenile Court, and the Supreme Judicial Court of Massachusetts, could naively accept medical testimony regarding

On February 2, 2006, Not Dead Yet, the national disability rights group, called for an investigation into the shoddy medicine that led to a court order to remove life-support from 11-year-old Haleigh Poutre just days after her admission to Massachusetts' Baystate Medical Center. Allegedly beaten by her adoptive mother and stepfather, Haleigh suffered a severe brain injury and was hospitalized in September 2005. Four months after being declared "virtually brain dead" and in an "irreversible coma" she was responsive, interactive and breathing on her own. In late January, she was moved to a rehabilitation center for children. If the court order had not been appealed, Haleigh would now be dead.

According to Not Dead Yet, investigations are imperative into:

- ◆ How doctors at Baystate Medical could be so wrong in their hasty diagnosis that Haleigh had "no chance of recovering cognitive or sensate functioning" and that she "cannot hear, feel or respond." They presented their diagnosis as medical fact, whereas any prognosis following a brain injury must be provisional. These doctors must answer to charges of incompetence and negligence. Do they have expertise regarding brain injuries? Furthermore, have they withdrawn life-support in similar

life and death without additional investigation. People with disabilities have a lot of experience with medical hubris regarding the quality of our lives, and know firsthand how mistaken and prejudicial doctors can be. The courts must stop their slavish deference to "established medical opinion," which is continually changing.

- ◆ How the courts understand the concept of "dignity." On October 5, barely three weeks after Haleigh Poutre's admission, a juvenile court judge ruled that her "dignity and quality of life would be most respected by withdrawing both the ventilator and the feeding tube." Now that Poutre is responsive, does she have her dignity back? Or is she still at risk of being viewed as living an undignified life?

Not Dead Yet leads the disability community's opposition to legalized assisted suicide, euthanasia and other forms of medical killings.

Information

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In 1938, the Euthanasia Society of America (ESA) was founded in New York. In 1939, ESA proposed legislation for "voluntary" euthanasia. According to attorney Charles Nixdorff, Treasurer, "the society hoped eventually to legalize the putting to death of non-volunteers beyond the help of medical science." ESA's president, Dr. Foster Kennedy, a neurologist, speaking before the Society of Medical Jurisprudence at the Academy of Medicine, urged legalizing euthanasia "primarily in cases of born defectives who are doomed to remain defective." These statements reveal the ultimate goal of the "right to die" movement: the legalization of the "right to kill" persons who are deemed "defective" with or without their consent.

After numerous unsuccessful attempts to legalize euthanasia, ESA leaders realized that they must first change the mindset of the nation.

Information

LifeTree, Inc., a pro-life organization, has a detailed timeline at www.lifetree.org/timeline.html.

Smith, Wesley J. *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder*. Spence Publishing, 2003.

Organizations

ESA: Euthanasia Society of America. Later names were SRD: Society for the Right to Die; Choice In Dying; PFC: Partnership For Caring; Last Acts Partnership.
EEC: Euthanasia Education Council (arm of ESA). Later names were Concern for Dying; Choice In Dying.
AAHS: Americans Against Human Suffering. Later named Americans for Death with Dignity.
CID: Compassion In Dying Federation. Now called Compassion & Choices.
HS: Hemlock Society. Later named End-of-Life Choices. Now called Compassion & Choices (after uniting with CID).

Abbreviated Terms

LW: Living Will
PVS: Persistent Vegetative State
PAS: Physician-Assisted Suicide
DWD: Death with Dignity
CSA: Controlled Substances Act

1967

- ▶ ESA launches a massive educational campaign, establishing the Euthanasia Education Council (EEC) and introducing the Living Will (LW) as a tool to promote discussion of euthanasia.

1973

- ▶ The first state LW-type legislation fails in Florida thanks to strong opposition from advocates for retarded children and the FL Catholic Conference. Rep. Walter S. Sackett, MD, introduced the bill as a cost-saving measure that would save billions of dollars "if the state's mongoloids were permitted to succumb to pneumonia."



1975

- ▶ ESA becomes the Society for the Right to Die (SRD), expunging "euthanasia" (a reminder of the Nazi killing program) from its name.

1976

- ▶ SRD's first success; the California "Natural Death Act," a LW law, passes.
- ▶ Basing its decision on the "right to privacy," a NJ court permits a ventilator to be removed from 21-year-old Karen Ann Quinlan, diagnosed to be in a persistent vegetative state (PVS). She unexpectedly lives for nine more years, requiring only ordinary care, including tube feeding.

1980

- ▶ British journalist, Derek Humphry, immigrates to the U.S. He and his second wife, Ann Wickett, start the Hemlock Society (HS) in CA. (In 1975, Humphry had helped his first wife kill herself and later wrote *Jean's Way*, a book recounting her "suicide.") Hemlock's purpose: to promote death-on-demand without any restrictions.
- ▶ "Dear Abby" promotes the Living Will in her advice column and is credited by SRD for an avalanche of requests for the document.



1984

- ▶ 22 states and the District of Columbia have adopted LW laws.

1986

- ▶ At a conference titled "A New Ethic for the New Medicine," the American Medical Association's Council on Ethical and Judicial Affairs issues this policy: "Even if death is not imminent, but a patient's coma is beyond doubt irreversible, ...it is not unethical to discontinue all means of life-prolonging medical treatment (including) medication and artificially or technologically supplied respiration, nutrition and hydration."
- ▶ HS forms Americans Against Human Suffering (AAHS) to seek legalization of "physician-aid-in-dying" (medical homicide).

1987

- ▶ 32-year-old Nancy Ellen Jobes dies from dehydration at her parents' request. Even though two neurologists agreed that she was aware, responsive and purposeful, the NJ Supreme Court upheld lower court decisions that family members may refuse medical care without clear evidence of a patient's wishes. SRD

participated in this and all early "right to die" court cases.

- ▶ In his book *Setting Limits*, Daniel Callahan, director of the Hastings Center (a bioethical think tank), proposes rationing medical treatment after a certain (unspecified) age. This is consistent with previous statements, such as, "Given the increasingly large pool of superannuated, chronically ill, physically marginalized elderly, [denial of food and water] could well become the non-treatment of choice..."

1988

- ▶ AAHS fails to gather enough signatures to place its "physician-aid-in-dying" initiative on the CA ballot. Humphry calls the effort "a valuable dress rehearsal."
- ▶ The American Association of Retired Persons (AARP) is congratulated by HS of IL for publishing an article promoting Hemlock, SRD, and Concern for Dying.

1989

- ▶ HS moves its headquarters to Oregon, planning to eventually place a "physician-assisted suicide" (PAS) initiative on the OR ballot.
- ▶ Medical journals increasingly give favorable treatment to assisted suicide and euthanasia, setting the stage for physicians' acceptance of medically imposed death.

1990

- ▶ In Michigan, unemployed pathologist Jack Kevorkian hooks Janet Adkins to his "self-execution

machine." His first known victim, Adkins, was a 54-year-old Oregon woman in an early stage of Alzheimer's disease. Criminal charges against Kevorkian are dropped, but a judge orders him not to use the machine again.

Thumbing his nose at the legal system, he goes on a killing spree.

- ▶ The U.S. Supreme Court, in its first termination of food and fluids case, *Cruzan v. Missouri Department of Health*, upholds Missouri's requirement that there be "clear and convincing evidence" of an incompetent patient's wishes. Nevertheless, 33-year-old Nancy Cruzan is starved and dehydrated to death after a lower court finds new evidence—an alleged conversation she had 12 years prior—"clear and convincing."
- ▶ The "Patient Self-Determination Act" (federal law forcing health care facilities and programs to promote Living Wills) is enacted.

1991

- ▶ D. Humphry's *Final Exit* (how to commit suicide manual) hits NY Times best seller list. This book has been found next to the bodies of suicide victims.
- ▶ Washington voters reject the "Death With Dignity" (DWD)—assisted suicide—initiative placed on the ballot by the WA State Chapter of HS, led by Ralph Mero, a Unitarian minister.
- ▶ Choice in Dying forms by re-merging SRD and Concern for Dying (which split from SRD in 1979). It promotes "end-of-life choices" through education and distribution of LW documents.

1992

- ▶ Americans for Death with Dignity (formerly AAHS) tries again in CA, collecting enough signatures to put a PAS initiative on the ballot. Voters reject it.

1993

- ▶ Compassion in Dying (CID), an HS spin-off, is founded in WA State to counsel the terminally ill and help them "with personal assistance, if necessary, to intentionally hasten death." Ralph Mero is CID's first executive director and president.

1994

- ▶ The Oregon DWD Act is narrowly approved by voters. Legal challenges ensue, blocking this PAS measure from taking effect.
- ▶ Every state now has some type of

"The only thing necessary for evil to triumph is for good men to do nothing."

ed Death in America

advance directive (LW or Durable Power of Attorney for Health Care) law.

1996

- After Jack Kevorkian assists the suicides of two women with non-terminal disabilities and is acquitted, disability activists form NOT DEAD YET. NDY makes news by picketing Kevorkian's home and conducting a sit-in at the Denver HS office. Disability rights groups' energetic opposition to assisted suicide becomes a "thorn in the side" of assisted suicide advocates.
- Barbara Coombs Lee replaces Mero at the helm of CID. She helped draft, promote, and defend the Oregon PAS law (DWD Act). Under her, CID becomes a well-funded national organization.

1997

- President Clinton signs the "Assisted Suicide Funding Restriction Act" prohibiting federal funds from paying for or promoting assisted suicide.

- The U.S. Supreme Court unanimously upholds the right of states to prohibit PAS. This decision overturns the 9th Circuit Court of Appeals ruling that WA State's law prohibiting assisted suicide is unconstitutional and the 2nd Circuit Court ruling that NY has no rational interest in preventing assisted suicide for the terminally ill. CID had initiated these challenges of laws forbidding PAS.
- A court clears the way for the Oregon DWD Act to go into effect; physicians may now write prescriptions for suicide. Oregonians vote down a bill to repeal the law.

1998

- Michigan voters crush a PAS measure 71%-29%. In ensuing years, the "right to die" movement meets with failure after failure in state after state and numerous states strengthen existing laws forbidding PAS.

1999

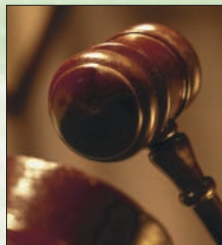
- After assisting the deaths of at least 130 people, Kevorkian is convicted on one count of second-degree murder. He had videotaped himself injecting lethal drugs into Thomas Youk, a man with Lou Gehrig's disease. CBS "60 Minutes" aired the video in 1998. It was used as evidence against Kevorkian. He is serving 10-25 years in prison.

2000

- 62-year-old Choice in Dying lays the groundwork for Partnership for Caring (PFC), votes to dissolve itself, and transfers its programs and staff to PFC.
- In Jan., a FL judge rules that Terri Schiavo's husband Michael can order the removal of her feeding tube. Terri is brain-damaged, not terminally ill. Her parents fight desperately for her life.

2001

- In Nov., U.S. Attorney General John Ashcroft announces that the Controlled Substances Act (CSA) prohibits the use of federally controlled drugs for assisted suicide in Oregon because it is not a legitimate medical purpose.



2002

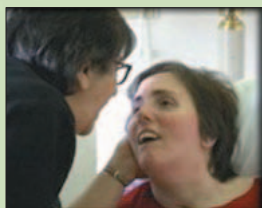
- Oregon and assisted suicide supporters challenge Ashcroft. U.S. District Judge Robert E. Jones rules in favor of OR Justice Department attorneys appeal to the 9th U.S. Circuit Court of Appeals.

2003

- The Hemlock Society changes its name to End-of-Life Choices.
- In a dramatic turn of events, on 10/21, the FL legislature enacts "Terri's law," permitting Gov. Jeb Bush to order Terri Schiavo's feeding tube reinserted after six days without food or water. (See p.12)
- In Dec., Partnership for Caring (ESA descendant) and Robert Wood Johnson Foundation's Last Acts program merge to form Last Acts Partnership.

2004

- On 3/20, Pope John Paul II definitively declares that providing patients in "vegetative" states with tube-administered food and fluids is "morally obligatory," and that no judgment on their quality of life could justify "euthanasia by omission." JPPI also states, "A man, even if seriously ill or disabled in the exercise of his highest functions, is and always will be a man, and he will never become a 'vegetable' or an 'animal.'"
- On 5/6, a judge declares "Terri's Law" unconstitutional. Gov. Bush



appeals and receives a stay while the ruling is reviewed.

- On 5/26, the 9th Circuit Court rules 2-1 that the U.S. Attorney General cannot penalize Oregon physicians who assist suicides by prescribing controlled substances (narcotics).
- In Nov., CID (headquartered in Portland, OR) and End-of-Life Choices (Denver, CO) merge to become Compassion & Choices, hoping to be a more powerful entity to lobby states to enact PAS laws (in other words, trying to jump-start a movement that's been stalled since 1994).
- Last Acts Partnership ceases operations after 66 years of working to change the mindset of this nation. (Note: The current president and CEO of the National Hospice and Palliative Care Organization, Donald Schumacher, was vice chair of the board of directors of Partnership for Caring and its Director of National Policy. Hospice has been infiltrated by the euthanasia/assisted suicide movement.)

2005

- On 3/31, Terri Schiavo dies of dehydration after all efforts by her parents, numerous physicians, disability rights groups, pro-life organizations, concerned citizens, the Legislature and Governor of Florida, the U.S. President and Congress fail to halt Judge

Save a Life!

Become a patient advocate to safeguard the welfare of a patient in the hospital or health care system. Patient advocates may accompany a medically vulnerable person to doctor appointments or stay with the person when hospitalized. Particularly in need of advocates are people whose lives are devalued in our society—those who are mentally or physically disabled, chronically ill, elderly, incurable, or poor.

Many hospitals are short-staffed. This often results in overuse of tranquilizers or physical restraints for patients who are restless or demanding, feeding tubes for patients who can swallow but are in need of assistance with meals, and call bells ignored when help is urgently needed. The advocate can soothe the restless patient, prevent him from pulling out tubes or falling out of bed, assist with meals, offer drinks of water, go for help in an emergency, etc.

Some hospital personnel perceive certain patients as being of "low value" and therefore give them less care because they think they would be "better off dead." The advocate's presence will encourage hospital staff to be more attentive to the patient's needs.

The most important role the patient advocate can play is to be a visible ally for the patient—a sign to the world that this patient is valued and should be treated with care.

Information

Wolfensberger, Wolf. *A Guideline on Protecting the Health and Lives of Patients in Hospitals, Especially if the Patient is a Member of a Societally Devalued Class*. 2nd Ed. 2005. To order, contact: Syracuse University Training Institute, 800 South Wilbur Avenue, Suite 3B1, Syracuse, New York 13204.

Case in Point

Salvatore Crisafulli, an Italian, was considered by doctors to be in a "deep coma" and "nearly dead" after being injured in a 2003 road accident. He began to show signs of alertness in July 2005. About three months later, he said his first word, "Mamma." Crisafulli was quoted as saying, "The doctors said that I wasn't conscious, but I understood everything and I cried in desperation." (Reuters, 10/5/05)

Victory is for good men to do nothing."

— Edmund Burke

George W. Greer's unjust and cruel order that Terri be denied all food and water until dead.

- A PAS bill, the deceptively named "California Compassionate Choices Act," is introduced in the CA legislature. Support is lacking in both the Assembly and the Senate, so the bill's authors turn it into a 2-year bill, meaning it may be voted on in 2006. Facing defeat, Californians for Compassionate Choices blame media for using the "negative" term "assisted suicide" to describe their bill, and urge the media to use "more neutral" terms such as "death with dignity," "right to die" and "end of life choices."

2006

- On 1/17, in *Gonzales v. Oregon*, the U.S. Supreme Court rules 6-3 that the CSA does not prohibit the use of federally controlled substances for PAS. However, contrary to some media reports, the Court does not endorse assisted suicide. (See p.3)

Thirsty? Too Bad.

Widespread legal and medical endorsement of death by dehydration and starvation has led to confusion. Is it right or wrong to withdraw food and water from seriously ill, mentally impaired or persistently non-responsive (so-called "vegetative") patients?

It is important to distinguish between appropriate medical decisions and discriminatory decisions based on value judgments:

- ♦ When a person's body is shutting down during the natural dying process, or when a person is unable to receive food and fluids without harm, it is medically appropriate to stop providing food and water. In these cases, patients die naturally from their disease or injury.
- ♦ When a person is not dying (or not dying quickly enough), food and fluids—whether provided by mouth or tube—are withdrawn because the person is viewed as having an unacceptably low "quality of life" and/or as imposing burdens on others. Some people are even described as "vegetables" or "vegetative"—dehumanizing terms. These judgments on the value of individual human lives are used to justify deliberately killing them by dehydration and starvation.

Consider the cases of two elderly women. In 1984, 92-year-old Mary Hier had lived in a state hospital for over fifty years. Demented, but happy, she thought she was the Queen of England. Mary was not terminally ill, but had needed a feeding tube for many years. When her gastrostomy (stomach) tube became dislodged, a court denied permission to replace it, declaring that it would be "a major medical procedure" with "relatively high risk" due to her

age. Just as Mary's case was being reported, the same newspaper carried another story about a 94-year-old woman who was doing well after "minor surgery to correct a nutritional problem." The surgery, performed under local anesthesia on an outpatient basis, was the insertion of a gastrostomy tube. The woman was Rose Kennedy, matriarch of a rich and politically powerful family. Mary Hier's life would have been prematurely ended without last minute intervention by a physician and an attorney who exposed the inequity. Her tube was replaced. Both women lived for a number of years longer.

In too many instances, whether inserting a feeding tube is considered a "major" or "minor" medical procedure depends upon whether the person is viewed by others as expendable or valuable, burdensome or beloved.

Advocates of euthanasia assert that providing food and water to patients is medical treatment that may be withheld or withdrawn. On the contrary, food and water are basic human needs and therefore basic human rights.

Feeding tubes are used for various reasons. Tube-feeding is often simpler, less costly and safer than spoon-feeding a patient who is a slow eater or chokes on food. It may be necessary for comfort, to ensure adequate nutrition and hydration or to sustain life when a person is unable to swallow. The nourishment provided through a tube is real food and water, not "artificial nutrition and hydration."

Yes, feeding tubes are artificial. So are electricity, running water, air-conditioning, cars and telephones. As demonstrated in the wake of

Hurricane Katrina, people die without these "artificial life supports." Should we therefore take away all life-sustaining technologies so that people who would die without them can die naturally?

When a mother is unable to breast-feed, she bottle-feeds her baby. Technically this way of feeding a baby is "artificial life support." If a mother refuses to bottle-feed and instead says, "Let nature take its course," no one would consider her helpless child's death to be natural. Likewise, to refuse to tube-feed a helpless, otherwise non-dying patient results in a very cruel and unnatural death.

Dr. William Burke, a St. Louis neurologist, describes what happens to patients as they die from dehydration:

They will go into seizures. Their skin cracks, their tongue cracks, their lips crack. They may have nosebleeds because of the drying out of the mucus membranes, and heaving and vomiting might ensue because of the drying out of the stomach lining. They feel the pangs of hunger and thirst. Imagine going one day without a glass of water! Death by dehydration takes 10 to 14 days. It is an extremely agonizing death.'

Food and fluids do not become "treatment" simply because they are taken by tube any more than penicillin and Pepto-Bismol become "food" when taken by mouth. Those who claim otherwise do so to advance their own agenda. In 1984, at a World Federation of Right to Die Societies conference, bioethicist Dr. Helga Kuhse explained the strategy of euthanasia advocates:

If we can get people to accept the removal of all treatment and care, especially the removal of food and fluids, they will see what a painful way this is to die, and then, in the patient's best interest, they will accept the lethal injection.

Death by dehydration and starvation is inhumane. Nonetheless, in every state it is now legal to impose death on non-dying patients by taking away their food and water. These laws are unjust and discriminatory. They imply that some people are "better off dead" and society is better off without them. They open the door to medical murder by lethal injection.

"Always to care, never to kill," has been the constant motto of honorable medical professionals. No law can make killing patients, regardless of their perceived "quality of life," medically or morally right.

1 Smith, Wesley J. "Dehydration Nation," *The Human Life Review*. Fall 2003, Vol. XXIX, No. 4, pp. 69-79.

CaseinPoint

Ted Stith, Sr., an up-state New York farmer and auctioneer who suffered a stroke while on vacation in Florida, died February 1st in a Florida Hospice on his eighth day without food or water. His son had agreed to removal of the feeding tube. However, there was no evidence that he wanted food and water withheld. According to a good friend who had flown to his bedside, Mr. Stith had indicated that he wanted to live, was improving, and had asked for water. (*North County Gazette*, 2/1/06)

In March 2005, people from all over the country made their way to Florida to pray for Terri Schiavo outside the hospice where she was being dehydrated to death. (See p.12) The media were mostly unsympathetic to these last friends of Terri and their expression of outrage that a court had seen her disability as reason to impose a death sentence. John Zarella, covering the case for CNN, described their concern as "religious zealotry" and intimated that they were "extremists" akin to criminals who murder abortion doctors.

Incredibly, on the same program, Zarella portrayed hundreds of people working to save two dozen dolphins as heroes. He reported, "The



volunteers are in the pool 24/7 holding the animals and keeping their blowholes out of the water so they can breathe. A veterinarian injects the dolphins with vitamin E to help with muscle cramping. These mammals are unable to eat on their own. Kate Banick uses a feeding tube to get them the nutrition they need." Not a word about zealotry or extremism.



Thanks for all the fish!

It is a tragic irony that, in pre-World War II Germany (1933), strong animal protection laws were passed. Fifteen years later, the Nuremberg Tribunal declared the Nazi euthanasia program a "crime against humanity." U.S. Brigadier General Taylor, chief counsel, concluded, "If the principles announced in this law had been followed for human beings as well, this indictment would never have been filed. It is perhaps the deepest shame of the defendants that it probably never occurred to them that human beings should be treated with at least equal humanity."

Who will sit in judgment on the United States?

Are You Sure You'd Never Want to be "Hooked Up to a Machine?"

Your life or the life of a loved one may depend on having correct information about the ventilator, commonly called a "respirator."

Respiration is a bodily function, not a machine's function. It can only occur when the body's respiratory and circulatory systems are intact and functioning. A ventilator is an aid to breathing. The ventilator machine

supports the ventilation part of breathing—moving air into and out of the lungs. But, it does not and cannot cause the other part of breathing—respiration. Thus, the machine should always be referred to by its accurate name, "ventilator."

Many people with disabilities use ventilators every day of their lives to assist their breathing. For them, a ventilator is a necessity of life which allows them not only to continue living, but to breathe easier and enjoy life to its fullest. The ventilator is also commonly and effectively used to save lives.

I had not given much thought to the indispensable role that a ventilator plays in the healing process until three real-life incidents brought the truth home to me.

My 41-year-old nephew was suffering from shocked-lung syndrome after being injured in an automobile accident. This is a condition in which the elasticity of the lungs is greatly curtailed, causing intense pain and severe shortness of breath. To give his body a chance to heal without fighting for breath, the doctors induced a comatose state and put him on a ventilator. He was on the ventilator for more than three weeks. His life was hanging by a thread or, more literally, a machine. When he was finally taken off the ventilator, his body took over, eventually completing the healing process. Today he is back working at his heavy-duty construction job—thanks to the ventilator and endless prayers.

In the second incident, a dear friend

sustained a head injury. Because his traumatized body started to shut down following surgery to close the wound, he too was put into a medically induced coma and hooked up to a ventilator. He was in critical condition. After five days, he was taken off the ventilator and his natural breathing functions took over. This friend, who at 80 doesn't

believe in retirement, is back working full-time, none the worse for the wear.

Imagine the outcome had he signed a Living Will that stated he would never want to be put on a "respirator." If you have made a statement to this effect, either orally or in writing, I advise you to promptly and emphatically rescind it.

In the third incident, a friend had a cardiac arrest. He was taken to the hospital by ambulance and subsequently pronounced "brain dead." The attending physicians wanted to disconnect life support, but his wife wouldn't hear of it until all of their children could get home to say their goodbyes. After 72 hours, the sorrowing children had bid their father farewell. When life support was disconnected, their father sat up in bed and started talking to the family! He went home shortly thereafter and the family was able to enjoy his company for four more years before he was called home to his Maker. WHAT IF his wife had

given consent to stop life support before his body's own healing powers had a chance to take their course with the aid of the ventilator?

I am now an enthusiastic believer in the healing benefit of the ventilator. We must all do our part to dispel the mistaken assumption that use of a ventilator is an extraordinary or heroic measure used only to temporarily prolong life. Its role in protecting and preserving lives must be made more widely known. Providing accurate information about medical technology's benefits gives people the ability to make truly informed treatment decisions.

By Marlene Reid, President Emeritus, Human Life Alliance



FOLLOW THE MONEY

For some people in government and health care, limiting medical care and ending the lives of certain patients makes economic sense. One expert put it bluntly, "A quick death is a cheap death."

"Futile care" used to mean that the patient would not benefit from treatment—a medical judgment. In recent years, the term has been redefined to mean that the patient's life is deemed not worth the investment of life-sustaining treatment—a value judgment. "Futile care theory" is used to rationalize withholding treatment, and even food and fluids, regardless of the patient's or family's wishes. Implicit in this new ethic is the profoundly unjust notion that some people have a duty to die.

Wesley J. Smith, in his book *Forced Exit*, suggests that money is "the most influential and dangerous force driving the euthanasia juggernaut." In fact, the push for Living Wills as cost-saving devices was the precursor to hospital "futile care" policies. The two work hand in hand. When a patient does not "choose" to forgo treatment, a "futile care" policy allows the hospital ethics committee to make that "choice" for him/her.

In 1977, Robert Derzon, head of Health Care Financing for the Department of Health, Education and Welfare, pointed out that the "cost-savings from a nationwide push toward 'Living Wills' is likely to be enormous." In 1987, Dr. Otis Bowen, Secretary of Health and Human Services (HHS), echoed Derzon in testimony before the Senate Finance Committee. In due course, the Patient Self-Determination Act became law, requiring facilities and programs that receive Medicare and Medicaid funds to

give every adult patient the "opportunity" to sign a Living Will. In 2005, HHS Secretary Mike Leavitt, speaking to hospital administrators, stated that encouraging new Medicare participants to write Living Wills "would not just save families anguish but would likely save the system a remarkable amount of money..."

Likewise, cost containment is the chief incentive for the "futile care" movement sweeping through our health care system. High-sounding motives such as "doing what is best for patients" and "saving families anguish" are simply camouflage.

One way to spot potential problems is to review a hospital's or nursing home's policy on the withdrawal or withholding of tube-feeding. The provision of food and water for a patient who is not otherwise dying is basic, ordinary care.

Unfortunately, this ethical norm is fast becoming the exception while imposed death by dehydration is becoming commonplace.



ORGAN DONORS WANTED: DEAD OR ALIVE!

Most people are not aware that many in the medical community are convinced that "brain death" is not true death.¹

Before organ transplantation became possible, physicians cautiously determined death in order not to embalm or bury people while still alive. Today, death is often declared for reasons not related to the patient's welfare—organ transplantation and cost containment. "Brain death" is sometimes hastily declared because the removal of vital organs (heart, lungs, liver, kidneys, etc.) must be done before the organs deteriorate due to cessation of blood circulation. It is the life that remains in donors that makes their organs useful.

Before 1968, a physician pronounced death when there was no breathing, no heartbeat and no response to stimulation. Today, a person can be judged "brain dead" while he/she has a beating heart, as well as normal pulse, blood pressure, color and temperature—all signs of life. How did this change occur?

The *Journal of the American Medical Association* published an article entitled "A Definition of Irreversible Coma" in 1968. This article included the Harvard Criteria which claimed that irreversible coma represented "brain death." The newly coined "brain death" allowed the "harvesting" of vital organs from comatose patients on ventilators.

A ventilator moves air into and out of the lungs. It is effective only when the patient's respiratory and circulatory systems are functioning. These systems working together add oxygen



to the blood, carry the blood with the oxygen to the cells of the body, and then take carbon dioxide from the cells back to the lungs to be exhaled. Respiration occurs in all living persons, including those who have been declared "brain dead."

By 1978, there were more than 30 different sets of criteria for determining "brain death." Every set since the first is less strict. For instance, the Harvard Criteria required that the patient be in a coma at least 24 hours. Later sets of criteria shortened the time to 12 hours, then six hours. Some criteria do not even require an electroencephalogram (EEG)—an

omission that could result in a patient with cortical activity (memory, feeling, emotion, etc.) being declared "dead."

Every set of criteria for "brain death" includes an apnea test. ("Apnea" means the absence of breathing.) This test, which has no benefit for the comatose patient and, in fact, aggravates the patient's condition, is done without the knowledge or consent of family members. The apnea test, during which the ventilator is turned off for up to 10 minutes, can induce "brain death" or cardiac arrest. Its sole purpose is to determine the patient's inability to breathe on his own in order to declare "brain death."



strated that 70% of victims of severe head trauma in a deep coma NOT SUBMITTED TO AN APNEA TEST could be recovered to NORMAL DAILY LIFE if their bodies were cooled down to 33 degrees Celsius for 12 to 24 hours ("short-term moderate hypothermia").

So, here is the transplant dilemma: Without the apnea test, the diagnosis of "brain death" is simply not possible, and without the diagnosis of "brain death," the transplantation of vital organs is not possible, or at least much more difficult. Because transplant surgery is one of the most profitable medical activities, medical professionals in the transplant system

"brain dead" using one set of criteria, but alive using a different set. Every transplant center agrees that death is whatever a doctor says it is.

Ironically, a patient regarded as "dead" (for transplantation or experimental purposes) is sometimes treated as alive. Suction and postural drainage are done to prevent pneumonia. The patient is turned to prevent bed sores. How can a dead person (cadaver) develop pneumonia or bed sores?

When the incision is made to remove organs, the donor often reacts by moving, grimacing and squirming, unless first given a paralyzing drug. Even paralyzed, his/her blood pressure and heart rate increase dramatically. The heart continues beating until the transplant surgeon stops it just before cutting it out. As a

doctor wrote in a letter to the editor of the *New England Journal of Medicine*, 11/17/94:

"The signs of life in brain dead patients...are very real and cannot be discounted in human terms, even if we have done so in public policy."



By Paul A. Byrne, MD, Clinical Professor of Pediatrics, Medical University of Ohio.

¹ "Are Organ Transplants Ever Morally Licit?" *The Catholic World Report* (CWR). 3/01; "Brain Death' Is Not Death," CWR. 3/05.

Organ Donors, NOT "Brain Dead"

Organs harvested from "brain dead" patients are not enough to meet demand. One response to this "crisis" is to "redefine donor eligibility," that is, to allow organs to be taken from another category of patients. The most recently "defined" donors are patients termed "hopeless" or "vegetative," usually shortly after suffering a severe stroke or devastating trauma, but not fulfilling any set of criteria for "brain death." Nancy Valko, a St. Louis intensive care nurse, explains, "Because of the legal acceptance of the so-called 'right to die,' families or patients can agree to have the ventilator turned off, a 'do not resuscitate' order written, and organs harvested if or when the person's breathing and heartbeat stop."

To ensure healthy organs, speed is of the essence. The patient is often taken to the operating room and prepared for surgery before the ventilator is turned off. As soon as the heart stops beating, cardiac death is declared. The organ retrieval team waits two to five minutes (sometimes less), then organ removal begins. The donor

may be paralyzed or given an anesthetic before the surgeon begins to cut, just in case the team acted too quickly.

This organ donation process has undergone several name changes in the last few years—"non-heart-beating organ donation," "donation after cardiac death," and most recently "donation from partially brain dead patients." In 2000, the Institute of Medicine set criteria for "donation after cardiac death," stating that the cessation of the patient's heartbeat must be "irreversible." It is impossible to determine "irreversibility" if the heart has stopped beating for five minutes or less. Resuscitation is a possibility even five minutes or more after cardiac arrest.

The Denver Post, 1/19/06, reported, "Organ donations from partially brain-dead patients—a controversial source—jumped tenfold in Colorado and Wyoming last year, the group that coordinates donations said."

This is major news, but unknown to most of the public.

refuse to acknowledge in public the detrimental effects of the apnea test. They also reject obtaining written consent because, if the apnea test was explained in detail, no family member who loves the patient would authorize it.

Since there is no universally accepted standard for determining "brain death," a person could be declared

Case in Point

For twenty years Sarah Scantlin could only blink her eyes in response to questions, questions her caregivers doubted she understood. At the age of 18, she was hit by a drunk driver, and suffered brain damage so severe that doctors told her father, "The daughter you had is gone." In February 2005, Sarah started to talk, surprising her family with a phone call to say "hello." When asked about 9/11, which occurred while she was unconscious, she said, "Bad, airplane, fire, building, hurt people." She'd been paying attention to the TV in her room all those years. (*CBS Transcripts*, "The Early Show," 8/4/05, 8/5/05)

Hospice Care: The Good, the Bad and the Ugly

"Hospice care is there to make it possible for people who are dying to live fully until they die."

Dame Cecily Saunders

Over 3,000 hospices operate in the United States, and each is a separate business entity with its own unique characteristics and quality of care. Many are operated by non-profit charitable organizations, a few remain largely voluntary, but increasing numbers are being operated by corporations. You can find excellent, traditional hospice care in all three categories.

Hospice caregivers deserve the utmost respect. We should never underestimate the difficulties that palliative caregivers endure and the dedication so many demonstrate. ("Palliative" describes care that comforts and relieves or moderates pain.) Unfortunately, in recent years, numerous incidents of unnecessary morphine dosages and premature withdrawal of food and water from patients have been reported by caregivers and administrators, families of hospice patients, medical examiners and attorneys. Hospice as an industry has become suspect.

Terminal Sedation and the Withdrawal of Food and Water

"Terminal Sedation" (TS) refers to controlling pain by giving an opiate, primarily morphine, in sufficient quantity to induce unconsciousness. Initially used as a last resort to relieve extreme pain when a person was dying, TS has been transformed into a form of slow euthanasia or assisted suicide. Deep sedation combined with the withholding of all medical treatment, including food and water, is becoming routine in many hospices and is legal in every state. Euthanasia has moved beyond the law, as it is difficult to tell whether the intent is to kill the patient or relieve his pain.

The World Health Organization

WHO concurs with experienced palliative care doctors and nurses who insist that pain can virtually always be controlled. Even in the most difficult situations, it is possible to have adequate pain control without rendering the patient comatose.¹ The original and true mission of hospice is to provide the dedication and time necessary for real palliative care—care that allows the patient to live as fully as possible until natural death.

From Charity to Big Business

Hospice in the 1960s and 1970s operated as a charitable service rendered primarily by volunteers.

In the 1980s, Medicare and Medicaid found it cost-effective to include hospice benefits. Consequently hospice became big business. The number of for-profit hospices and the number of Medicare recipients receiving hospice care more than doubled from 1992-1998. The National Hospice and Palliative Care Organization reported 3,300 hospice programs serving 900,000 patients in 2004.² Unfortunately, as government and insurance (most HMOs currently provide hospice benefits) dollars rolled in, both fraud and cost-containment measures followed.

Infiltrated by the "Right-to-Die" Movement

Recent developments confirm the suspicion that proponents of the "right-to-die" movement find hospice the ideal avenue to advance their efforts to legalize assisted suicide and euthanasia.

In 2000, Choice in Dying (formerly known as the Euthanasia Society of America), composed of right-to-die advocates, became part of a new organization, Partnership for Caring (PFC), founded by Dr. Ira Byock, a hospice physician.³

Thus, the "right-to-die" agenda began to infiltrate the hospice industry. In October 2002, J. Donald Schumacher, Vice-Chair for Public Policy for PFC, became President and CEO of the National Hospice and Palliative Care Organization (NHPCO), the largest organization of its kind.

In 2005 The Hospice Federation of America (HFA) published a controversial, eye-opening book entitled *Ethical Dilemmas at the End of Life*. One of its authors, Thomas Attig, tries to convince readers that there is no moral culpability in assisted suicide.⁴ In another chapter, Robert Kastenbaum affirms the legitimacy of euthanasia when he states, "With persistent vegetative states, it is the

question of passive or active euthanasia." He goes on to ask, "What about Alzheimer's disease?"⁵ Indeed, an increasingly acceptable practice is to admit non-terminally ill patients to hospice in order to "help" them die.

Hospice: Help for the Dying, Not Help in Dying

To be legally admitted to a licensed hospice, the patient must be suffering from a terminal untreatable illness with a life expectancy of six months or less. Hospice provides palliative care only—not cure. Hospices are not licensed to provide care (or help in dying) to non-terminally ill individuals with disabilities, brain damage, Alzheimer's disease or other forms of dementia.

Palliative care may be provided in a patient's home, a nursing home, a hospital or a hospice facility. Many patients prefer to be cared for in their own homes, but sometimes this is not feasible. It will take time and effort to choose a hospice. References from

friends, family, trusted physicians, medical personnel, or families who have had recent experience with the hospice being considered, are invaluable. Be sure to read the hospice's policies, especially those concerning the use of morphine,

withdrawal of nutrition and hydration, and the continuation/provision of medications and treatments for all conditions other than the terminal illness. As documented above, there are good reasons for suspecting hospices that use guidelines developed by NHPCO or who are affiliated with HFA.

Ethics Committees

Bioethics, the new philosophy of health care and medical ethics, with some notable exceptions, is based on a quality of life ethic—the belief that some people are better off dead. Often, the people who are least valued in bioethics are those who are most expensive to care for. Ethicists with a traditional sanctity of life

ethic—the belief that all human lives are valuable simply because they are human—are desperately needed. However, ethicists and the committees they oversee are typically committed to a school's particular philosophy. Their ethics are usually "consensus" based—not morally based. They frequently employ highly paid professionals, are endorsed by HFA and are known to use the guidelines developed by NHPCO.⁶

Hospice professionals (ethicists, social workers, etc.) can be very clever about offering "false compassion." Key emotive language includes: unbearable or uncontrollable pain; quality of life; loss of dignity; rationing of resources and cost effectiveness; ethical consensus; and futile care. The last is a term frequently used to justify the withdrawal of food and water. A recent study in Oregon found that the most common reasons patients requested assisted suicide were none of the above but rather "fear of future suffering," "fear of being a burden" and "losing independence."⁷ Hospice should help the patient deal with his fears, not grant his wish to die—or kill him without his consent.

By Tracy Berntsen
Human Life Alliance

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Terri Schindler Schiavo: A Senseless Death

In 1990, 26-year-old Terri Schindler Schiavo suffered brain damage when she mysteriously collapsed and stopped breathing for a period of time. Fifteen years later, on March 31, 2005, Terri died of dehydration after 13 days without food or water. Her husband, Michael Schiavo, had obtained judicial approval to remove her feeding tube. Woodside Hospice in Pinellas Park, Florida, carried out her death sentence.

Michael Schiavo was given the "Guardian of the Year Award" in 2005 for his successful campaign to end the life of his wife. That some in our society applaud the murder of a disabled woman is deplorable. What makes Terri's case stand out is the public outcry in support of her right to live. More than 100,000 people contacted Florida Governor Jeb Bush, pressing him to save Terri's life.

The real heroes are Terri's parents, Bob and Mary Schindler, who were unrelenting in their battle to save their daughter from a cruel death. The highly publicized legal tug-of-war between Michael Schiavo and the Schindlers alerted millions to the fact that our judicial system has a history of sanctioning the treatment of disabled human beings in ways that would be criminal if done to a dog.

Terri's Condition

Contrary to media reports, Terri was not "brain dead," not terminally ill, not comatose and not on a ventilator. In 2002, Dr. William H. Hammesfahr, a neurologist, evaluated Terri. He listed among his findings that she was responsive to her environment; responded to specific people best; tried to please others by doing activities for which she received verbal praise; attempted to verbalize; could swallow; and could feel pain. Numerous other physicians provided affidavits disputing the claim that Terri was in a persistent vegetative state (PVS) and stating that improvement might occur with therapy.

Court Battles

Almost three years after Terri's collapse, a medical malpractice jury awarded \$700,000 for Terri's ongoing medical care and \$300,000 to Michael for loss of companionship. He had told the jury that he wanted to take care of Terri for the rest of her life. Shortly thereafter, Michael denied Terri all forms of rehabilitation and antibiotics for infections. When she did not die from neglect, he sought to have her feeding tube removed. Terri's parents vehemently objected and asked to be named Terri's guardians.

In January 2000, Judge George Greer, County Circuit Court, conducted a hearing at which Michael argued that, before her collapse, Terri had told him that she would not want to be kept on life support. Why had he never mentioned this before or during the malpractice suit? Terri had left no written evidence of her wishes and her parents insisted that she would

never have made such a statement. Nevertheless, Greer ruled that Michael could order all food and fluids withheld from Terri. The Schindlers appealed.

At issue was whether Terri was in a persistent vegetative state. Under Florida law, only those who are PVS or terminally ill may be dehydrated to death. The 2nd District Court of Appeals ordered Judge Greer to hold an evidentiary hearing to determine her condition. The two physicians chosen by Michael and one appointed by the judge testified that Terri was PVS. The two physicians chosen by the Schindlers found that she was not PVS. Greer ruled that Terri was PVS.

On October 15, 2003, Michael had Terri's feeding tube removed.

Six days later, the Florida legislature enacted "Terri's Law." The law allowed Governor Bush to order Terri's feeding tube

reinserted. Terri recovered from six-and-a-half days of dehydration while Michael, assisted by the American Civil Liberties Union, again went to court. On May 6, Judge W. Douglas Baird, County Circuit Court, found "Terri's Law" unconstitutional. Governor Bush filed an appeal and got an automatic stay, but Florida's Supreme Court upheld Baird's ruling.

The Schindlers, now desperate to save Terri, appealed all the way to the U.S. Supreme Court, which refused to hear the case. Time was running out.

On March 17, 2005, Terri's feeding tube was once again removed. A few days later, the U.S. Congress overwhelmingly approved an act that gave the federal court in Tampa jurisdiction to review the facts of the case and determine whether Terri's constitutional rights were violated. President Bush quickly signed it into law, but the court defiantly refused to review the case. For Terri, this time, there would be no stay of execution.

Anything But Peaceful

In the final 72 hours of her life, Terri's tongue and throat were dry, cracked and raw. Her eyes were bloodshot and bleeding. In the last 26 hours, she panted rapidly and couldn't catch her breath. Terri's brother, Bobby, called her death "grotesque."

Terri's death was not only wrong because it was horrendously painful, but also because nutrition and hydration should be considered basic care.

The soul-searching question we must ask ourselves is: Are we at peace with dehydrating disabled people to death, or does it haunt us?



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www.terrisfight.org
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On March 31, 2005, my sister, Terri Schindler Schiavo, died from the effects of dehydration. Judge Greer ordered that my beloved sister die this unnatural and gruesome death by ordering that her feeding tube be forcibly removed from her without her consent. My physically healthy sister lived in a neurologically compromised state, for reasons that are still unknown, and my family struggled for 12 years trying to protect her. We wanted nothing but permission to care for Terri for the span of her natural life.

Terri was not hooked up to machines, not terminally

A Brother's Grief

ill, and not succumbing to any killer disease. She was disabled. She was dependent on others. Terri was still very much alive, a woman and a person in my family's eyes, but most importantly, in the eyes of God.

My family was forced to watch my sister suffer through the grisly effects of terminal dehydration. With each passing day, Terri appeared weaker, thinner, more frightened and so very wronged. I watched as my family begged for her life and as healthcare professionals turned

a blind eye to her suffering. I listened to proponents of the so-called "right to die" coax news audiences into the belief that my sister was enduring a gentle, peaceful, and euphoric demise. I sat on the corner of her bed and held her thinning hands, trying so hard to understand that what I was witnessing was actually real. When Terri passed from this world, she took a very tangible piece of me with her.

No human being or agency should have the authority to pronounce an innocent person, such as my sister, "unworthy of life."

By Bobby Schindler